Regence MedAdvantage LEOFF 1 Retirees (PPO) offered by Regence BlueShield

Group Retiree Annual Notice of Changes for 2016

You are currently enrolled as a member of Regence MedAdvantage LEOFF 1 Retirees . Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You may make changes to your Medicare coverage for next year during your Annual Enrollment Period.**

Additional Resources

- Please contact our Member Services number at 1-888-319-8904 for additional information. (TTY users should call 711). Hours are from 8:00 a.m. to 8:00 p.m., Monday through Friday (from October 1 through February 14, our telephone hours are from 8:00 a.m. to 8:00 p.m., seven days a week).
- Member Services has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This information is available in electronic format and may be available in other formats.

About Regence MedAdvantage LEOFF 1 Retirees

- Regence BlueShield is a Medicare Advantage Plan with a Medicare contract. Enrollment in Regence BlueShield depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Regence BlueShield. When it says "plan" or "our plan," it means Regence MedAdvantage LEOFF 1 Retirees .

Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It's important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Sections 1.2 and 1.5 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 1.3 for information about our Provider Directory.
- ☐ **Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with Regence MedAdvantage LEOFF 1 Retirees :

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change during Annual Enrollment Period you will automatically stay enrolled in our plan.

If you decide to <u>change</u> plans:

If you decide other coverage will better meet your needs, you can switch plans during the Annual Enrollment Period. If you enroll in a new plan, your new coverage will begin on January 1, 2016. Look in Section 3.2 to learn more about your choices.

Summary of Important Costs for 2016

The table below compares the 2015 costs and 2016 costs for Regence MedAdvantage LEOFF 1 Retirees in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the attached *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2015 (this year)	2016 (next year)
Monthly plan premium*	Please contact your benefits/trust office for premium rate information.	Please contact your benefits/trust office for premium rate information.
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $0 From network and out-of-network providers combined: $0	From network providers: $0 From network and out-of-network providers combined: $0
Doctor office visits	**In- and Out-of-Network:** Primary care visits: You pay a $0 copay per visit. Specialist visits: You pay a $0 copay per visit.	**In- and Out-of-Network:** Primary care visits: You pay a $0 copay per visit. Specialist visits: You pay a $0 copay per visit.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	**In- and Out-of-Network:** You pay a $0 copay per day for days 1 and beyond.	**In- and Out-of-Network:** You pay a $0 copay per day for days 1 and beyond.

Cost	2015 (this year)	2016 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copayment or Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $0 • Drug Tier 4: $0 • Drug Tier 5: $0	Deductible: $0 Copayment or Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $0 • Drug Tier 3: $0 • Drug Tier 4: $0 • Drug Tier 5: $0 • Drug Tier 6: $0

Annual Notice of Changes for 2016
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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2015 (this year)	2016 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	Please contact your benefits/trust office for premium rate information.	Please contact your benefits/trust office for premium rate information.

- Your monthly plan premium will be more if you are required to pay a late enrollment penalty.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving “Extra Help” with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. These limits are called the "maximum out-of-pocket amounts." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2015 (this year)	2016 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$0	$0 Once you have paid $0 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays and deductibles) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$0	$0 Once you have paid $0 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

Our network has changed more than usual for 2016. An updated Provider Directory is located on our website at regence.com/medicare. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **We strongly suggest that you review our current Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are still in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at regence.com/medicare. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2016 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay),* in your *2016 Evidence of Coverage.*

Cost	2015 (this year)	2016 (next year)
Home infusion services	You pay a $0 copay for home infusion services including : • Home health care • Part B Drugs • Part D Drugs • Infusion supplies	Separate cost sharing will be assessed as follows: **In- and Out-of-Network:** <u>Home Health Care</u> You pay a $0 copay. <u>Part B drugs</u> You pay a $0 copay. <u>Infusion supplies</u> You pay a $0 copay. **Part D drugs** Part D drugs are covered separately under the pharmacy portion of your plan. See Chapter 6 of your EOC for benefit and cost sharing details.
Vision care – Routine hardware	**In- and Out-of-Network:** The Plan pays up to $100 per calendar year towards frames and lenses and/or contact lenses.	**In- and Out-of-Network:** You pay a $0 copay towards one pair of eyeglass lenses per calendar year. The Plan pays up to $100 towards one set of frames per calendar year. **OR** the Plan pays up to $100 per calendar year towards contact lenses in lieu of glasses. Restrictions apply – see your EOC for more information.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope. The Drug List we included in this envelope includes many – *but not all* – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website (regence.com/medicare).

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **We encourage current members** to ask for an exception before next year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Member Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary in the first 90 days of coverage of the plan year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you currently have an approved formulary exception your coverage will continue into the new plan year until the end date specified in your approval notification letter. You will have to submit a new exception request for continued coverage after the end date specified in the letter. If the approval letter did not clearly identify the end date of the approved formulary exception, you are not required to submit a new exception request unless we notify you. We will send you written notice that your exception will expire at least 60 days prior to the end of the current plan year or the end date of the exception. Non-formulary drug exceptions are covered at the Tier 4 (non-preferred brand) tier.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you get "Extra Help" and haven't received this insert by September 30th, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 7.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the attached *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2015 (this year)	2016 (next year)
Deductible	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2015 (this year)	2016 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply, or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 – Preferred Generics:** You pay $0 per prescription **Tier 2 – Non-Preferred Generics:** You pay $0 per prescription **Tier 3 – Preferred Brand:** You pay $0 per prescription **Tier 4 – Non-Preferred Brand:** You pay $0 per prescription **Tier 5 – Specialty Drugs:** You pay $0 per prescription _____ Once your total drug costs have reached $2,960, you will move to the next stage (the Catastrophic Coverage Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 – Preferred Generics:** You pay $0 per prescription **Tier 2 – Generics:** You pay $0 per prescription **Tier 3 – Preferred Brand:** You pay $0 per prescription **Tier 4 – Non-Preferred Brand:** You pay $0 per prescription **Tier 5 – Specialty Drugs:** You pay $0 per prescription **Tier 6 – Select Care Drugs:** You pay $0 per prescription _____ Once your total drug costs have reached $3,310 you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Other Changes

Process	2015 (this year)	2016 (next year)
Ambulance	This service requires a prior authorization for non-emergent air transportation.	This service requires a prior authorization for all non-emergent transports for in-network services.
Cardiac rehabilitation	This service requires a prior authorization for in-network services.	This service does not require a prior authorization for in-network services.
Dialysis	This service does not require a prior authorization for in-network services.	This service requires a prior authorization for in-network services.
Durable medical equipment and related supplies	This service requires a prior authorization for certain high-dollar, in-network services.	This service requires a prior authorization for certain in-network services.
Home health care	This service requires a prior authorization for in-network services.	This service does not require a prior authorization for in-network services.
Mailing address for coverage decisions for medical care	P.O. Box 1271 MS E9H Portland, OR 97207-1271	P.O. Box 1827 MS B32G Medford, OR 97501

Process	2015 (this year)	2016 (next year)
Other healthcare professional	This service does not require a prior authorization for in-network services.	This service requires a prior authorization for certain in-network services.
Outpatient diagnostic lab services	This service does not require a prior authorization for in-network services.	This service requires a prior authorization for certain in-network services.
Outpatient mental health	This service requires a prior authorization for in-network services.	This service requires a prior authorization for certain in-network services.
Outpatient surgery, including ambulatory surgical centers and outpatient hospital	This service requires a prior authorization for in-network services.	This service requires a prior authorization for certain in-network services.
Premium payment options	There are 3 ways to pay your plan premium. See Chapter 1, Section 4.2 for details.	There are 4 ways to pay your plan premium. See Chapter 1, Section 4.2 for details.
Prosthetic devices, services and supplies	This service requires a prior authorization for certain high-dollar, in-network services.	This service requires a prior authorization for certain in-network services.
Pulmonary rehabilitation	This service requires a prior authorization for in-network services.	This service does not require a prior authorization for in-network services.
Tier 2 name change	Tier 2 is named Non-Preferred Generics.	Tier 2 is named Generics.
Tier 6 Select Care drugs	Tier 6 is not offered.	Tier 6 has been added. See your EOC for more information.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Regence MedAdvantage LEOFF 1 Retirees

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare during the Annual Enrollment Period, you will automatically stay enrolled as a member of our plan for 2016.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2016 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- --*OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2016*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Regence MedAdvantage LEOFF 1 Retirees .
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Regence MedAdvantage LEOFF 1 Retirees .
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
    - – *Or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it during the Annual Enrollment Period**.** The change will take effect on January 1, 2016.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2016, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2016. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors.

Statewide Health Insurance Benefits Advisors is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Statewide Health Insurance Benefits Advisor's counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Statewide Health Insurance Benefits Advisors at 1-800-562-6900. You can learn more about Statewide Health Insurance Benefits Advisors by visiting their website (http://insurance.wa.gov/about-oic/what-we-do/advocate-for-consumers/shiba/). You can write to them at Office of the Insurance Commissioner, P.O. Box 40256, Olympia WA 98504-0256.

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications);
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Washington has a program called Washington State Health Insurance Pool that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 5 of this booklet).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Early Intervention Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-877-376-9316.

SECTION 7 Questions?

Section 7.1 – Getting Help from Regence MedAdvantage LEOFF 1 Retirees

Questions? We're here to help. Please call Member Services at 1-888-319-8904. (TTY only, call 711.) We are available for phone calls from 8:00 a.m. to 8:00 p.m., Monday through Friday (from October 1 through February 14, our telephone hours are from 8:00 a.m. to 8:00 p.m., seven days a week). Calls to these numbers are free.

Read your 2016 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2016. For details, look in the 2016 *Evidence of Coverage* for Regence MedAdvantage LEOFF 1 Retirees . The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

You can also visit our website at regence.com/medicare. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to http://www.medicare.gov and click on “Find health & drug plans.”)

Read *Medicare & You 2016*

You can read *Medicare & You 2016* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048